Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005002	A. BUILDING: _____ B. WING _____	06/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST HOSPITALS INC	600 GRANT ST GARY, IN 46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of a State hospital complaint. Complaint IN 00125825 Unsubstantiated: lack of sufficient evidence. Date: 6-13-13 Facility Number: 005002 Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor Methodist Hospitals Inc is in compliance with 410 IAC 15-1.5-6, Nursing service, Indiana Hospital Licensure Rules. QA: claughlin 06/18/13	S 000		